# VIRGINIA INFORMED CHOICE

The Virgini[illegible]1)enrollment into the I[illegible]rt (DS) Waiver, 2[illegible]dividual wants to [illegible]T) referral is made. D[illegible]nsing/ licensed-p[illegible]heir license to provide services. Note that Substitute Decision-Maker (SDM) stands for either Authorized Representative or Legal Guardian.

This form is completed when an individual enrolls into the Intellectual Disability Waiver, Individual Family Developmental Disability D Waiver (DD Waiver) or the Day Support Waiver, when there is a request for a change in waiver provider(s), when new services are requested, if the individual wants to move to a new location, is dissatisfied with the current provider or when an RST referral is made.

## Individual/Substitute Decision Maker Choice of Provider

1. Share preferences for all types of services considering.

| Individual's preferences for types of services: | Substitute-decision maker's preferences for types of services (if applicable): |
|---|---|
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List the type services, not name of provider. The individual may want one type of support and the Substitute Decision-Maker (SDM) want something different.

*Complete the sections below to confirm that the following opportunities were discussed **before** making service choices under the waiver.*

2. I confirm that all of the following types of options available were discussed: ☐

*Own Home*
*Leased Apartment*
*Rental Assistance*
*Family Home*
*Sponsored Home (ID Waiver only)*
*Group Home (4 or fewer) (ID Waiver only)*
*Employment*
*Career Training/Education*
*Volunteer*
*Retirement*
*Other: _____*

3. I confirm that all of the following types of ID/DD/DS services were discussed (as available under the Waiver received): ☐

*Assistive Technology*
*Companion*
*Consumer-Directed Services*
*Crisis Stabilization*
*Day Support*
*Environmental Modifications*
*Personal Assistance*
*Personal Emergency Resp[illegible]*
*Prevocational*
*Residential Support*
*Respite*
*Services Facilitation*
*Skilled-Nursing*
*Supported Employment*

The support coordinator/case manager (SC/DDCM) describes options and supports for living and daily activities. Please refer to "Supporting Informed Choice: Resources for Support Coordinators/DD Case Managers"

4. I have been offered the chance to talk with other individuals receiving ID/DD/DS Waiver services who live and work successfully in the community or with their family members: *If desired, you or your support coordinator/case manager may contact a DBHDS Family Resource Consultant at (804) 894-0928 or (804) 201-3833 to connect with individuals and families who have waiver services. DBHDS licensed providers can be found at http://www.dbhds.virginia.gov/LPSS/LPSS.aspx.*

In making a decision, I/we considered, interviewed and/or toured the following:

| Services | Settings | Providers | Reason(s) selected or not selected |
|---|---|---|---|
| | | | |
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Setting means: family home, apartment, day support, etc. Record name of provider and reason selected or not.

5. Are any preferred options unavailable? ☐ Yes ☐ No

| If yes, list unavailable options: | |
|---|---|

Were there service types the individual/SDM wanted that weren't available? For example: The individual wanted to live in an apartment but cannot find in-home services.

6. As a result of discussing, interviewing and touring options, have your initial service decisions changed? ☐ Yes ☐ No

## Final Choice of Provider(s)

*If only one service or provider at this time is being chosen/changed check here* ☐

After being provided information on the types of settings (#2 above) and services available under the waiver (#3 above) and in my preferred area(s) of the state, opportunities to talk to other individuals and families, I have freely chosen the following services, support coordinator/case manager, settings and providers:

| Settings | Services | Providers |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| N/A | ID/DD/DS Support Coordination/Case Management | [Enter CSB Agency, Contractor or DD CM] |

Record the final selection of settings, services and providers.

ID/DD Support Coordinator/Case Manager explains the role of the RST to the Individual/SDM

**RST Referral**

7. RST Referral Form DMAS-460B must be completed if any of the following criteria is met:

a. Difficulty finding services in the community within 3 months of receiving a slot.
b. Choosing to move to a group home of five or more individuals.
c. Choosing to move into a nursing home or ICF-IID.
d. Pattern of repeatedly being removed from home.

*The Regional Support Team (RST) will review your selection of services to assure you have received information about all options available, explored supports and services in the most integrated settings, have knowledge of what's available to you in your preferred location and report on any preferred settings not available in your area. No action is required on your part and it is confidential. Any suggestions the RST offers will be shared directly with your support coordinator/case manager to follow up on with your consent.*

I am aware of the fact that I may contact my ID/DD/DS Support Coordinator/Case Manager at any point to seek assistance with resolving provider-related issues. I have the option of changing providers, including my ID/DD/DS Support Coordinator/Case Manager at my discretion. I am also aware that under certain conditions (described above), a Regional Support Team referral will be completed by my ID/DD/DS Support Coordinator/Case Manager. I have been made aware of the right to a fair hearing and appeal process.

I am aware that I have the potential to pay for some of my cost (patient pay), based on my income, and regardless of the amount of services received. I also understand that, if I chose Consumer-Directed Services, I bear the responsibility associated with employing my own personal assistants. I also understand there are services in both the ID/DD/DS Waiver for which I am responsible for a backup plan if there is a lapse in services.

The above information has been discussed with me. I understand that the ID/DD Support Coordinator/Case Manager and provider(s) will develop a PC ISP/Plan of Care with my assistance based on what I want and need.

_____ _____

Individual Signature/Date Substitute Decision Maker Signature (if applicable)/Date

_____

ID/DD Support Coordinator/Case Manager Signature & Date

☐ **Check if RST Criteria met and RST referral is being completed.**